



Choonara, Imti (2014) Why children do not receive treatment. Archives of Disease in Childhood . ISSN 0003-9888

Access from the University of Nottingham repository:

http://eprints.nottingham.ac.uk/3071/1/Why_children_do_not_receive_treatment_paper_2014.pdf

Copyright and reuse:

The Nottingham ePrints service makes this work by researchers of the University of Nottingham available open access under the following conditions.

- Copyright and all moral rights to the version of the paper presented here belong to the individual author(s) and/or other copyright owners.
- To the extent reasonable and practicable the material made available in Nottingham ePrints has been checked for eligibility before being made available.
- Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.
- Quotations or similar reproductions must be sufficiently acknowledged.

Please see our full end user licence at:

http://eprints.nottingham.ac.uk/end_user_agreement.pdf

A note on versions:

The version presented here may differ from the published version or from the version of record. If you wish to cite this item you are advised to consult the publisher's version. Please see the repository url above for details on accessing the published version and note that access may require a subscription.

For more information, please contact eprints@nottingham.ac.uk

Why children do not receive treatment

Imti Choonara

Each year, worldwide, almost seven million children under the age of five years die.¹ The majority of these children die from diseases that are treatable (gastroenteritis, pneumonia and malaria are three of the main causes). The main reason that these children die is that neither they nor their parents have access to healthcare. The two main reasons why people do not have access to healthcare are financial and geographical. Unfortunately, in many countries, healthcare is considered a commodity rather than a right. Many parents, therefore, cannot afford to purchase either the treatment or even the consultation that their child needs. This is highlighted in the paper by Njuguna *et al*² who describe how parents of children with cancer in a single centre in Kenya have to withdraw their children from treatment because of inadequate financial resources.

ACCESS TO HEALTHCARE

Healthcare is a basic human right. In 1948, the United Nations released the Universal Declaration of Human Rights. Article 25 stated: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control'. The failure of governments to provide universal healthcare results in the death of a significant number of children. This applies to high-income countries as well as low-income countries. The lack of universal healthcare is one of the reasons for the higher under-five-year mortality rate in the USA (8 per 1000 live births) than in neighbouring Canada and Cuba (6 per 1000 live births).¹ Both Canada and Cuba provide free universal healthcare to their citizens.

Many of the poorest people live in rural areas. These are less likely to have health facilities, and where health facilities do exist, parents may have to travel great distances with their ill child in order to obtain a medical opinion. UNICEF in its annual report on the state of the world's children

now records information regarding the percentage of children with diarrhoea who receive oral rehydration salts, and the percentage who receive antibiotics for suspected pneumonia.¹ India has a booming economy but a privatised healthcare system which fails to meet the needs of its children. This is illustrated by the fact that only 26% of children with diarrhoea receive treatment with oral rehydration salts.¹ The number of children who received antibiotics for suspected pneumonia is only 13%.¹ These figures are in sharp contrast to neighbouring Bangladesh which is significantly poorer than India but has ensured that 78% of children with diarrhoea receive treatment with oral rehydration salts, and 71% of children with suspected pneumonia receive antibiotics.¹ These figures help to explain why Bangladesh has a lower under-five-year mortality rate than India (46 vs 61, respectively).¹ Public services in Bangladesh have focussed on reducing inequalities in access to healthcare in the poorest sections of society.

ACCESS TO ESSENTIAL MEDICINES

It is ironic that India is one of the largest manufacturers of pharmaceutical medicines. Despite this, many of its citizens cannot afford to purchase the medicines that are required. Unfortunately, even if parents can afford to buy medicines, the medicines needed are often not available. WHO has identified the essential medicines that are needed for children. A study of 14 countries in central Africa highlighted that many of these medicines were unavailable in pharmacies.³ Governments and their ministries of health need to ensure that essential medicines are available in all areas, and also that they are within the financial reach of the poorest members of society. Pharmacies in isolated rural areas will have a smaller stock of drugs than pharmacies in large cities. It is important, therefore, to have a coordinated system whereby the larger pharmacies assist the smaller isolated pharmacies to ensure that appropriate medicines are available to patients as they are needed. This is not possible if every pharmacy is competing with each other. Cuba has shown that it is possible to establish a system ensuring that people in isolated rural communities have access to medicines.⁴

NEGLECTED DISEASES

Treatments are available for respiratory infections, malaria and gastroenteritis, but

unfortunately, for many diseases that are confined to low-income countries medicines have not been developed. WHO has identified 17 tropical diseases for which research into treatment has been neglected. Neglected diseases include Chagas disease, human African trypanosomiasis (sleeping sickness), dengue, leprosy, rabies, leishmaniasis, lymphatic filariasis and onchocerciasis (river blindness). There are few medicines available for these conditions, and often the medicines available are highly toxic. This is despite millions of people worldwide being affected. Pharmaceutical companies exist to make profits, and profits are more easily generated for diseases that affect individuals in high-income countries. It is important to remember that the initial antimalarials were only developed after World War II, when soldiers from the USA or Europe developed malaria. WHO needs to consider alternative ways of ensuring that funding is made available for research into the development of medicines for these diseases.

STIGMA

Children are dependent upon their parents as well as health professionals for treatment. Unfortunately, stigma associated with certain medical conditions is associated with parents choosing not to have treatment for their children. This is illustrated by epilepsy which affects over 10 million children worldwide.⁵ In many countries, most children do not receive treatment. It is estimated that in the Lao People's Democratic Republic, 90% of children with epilepsy do not receive treatment.⁵ Reasons for this include the widespread belief that epilepsy is a highly contagious disease. Large sections of the population would not even share a meal with someone with epilepsy.⁵ Many health professionals had received no training in epilepsy. One-third of doctors treating children had never diagnosed epilepsy, and one in four doctors working on a paediatric ward thought that epilepsy was contagious.⁵

The provision of universal education should help to reduce the effect of stigma. Stigma, however, is not only a problem in low-income countries. Mental health problems are one of the major causes of morbidity in young people in the UK. Despite this, there is considerable stigma attached to mental illness, and many young people and their families are reluctant to seek help. Additionally, many paediatric health professionals have a dismissive attitude towards mental health problems and consider them less important than other conditions.

ADVOCACY

Worldwide, it is the poorest children and their families who are usually deprived

Correspondence to Emeritus Professor Imti Choonara, Child Health, University of Nottingham, Derbyshire Children's Hospital, Derby DE22 3DT, UK; imti.choonara@nottingham.ac.uk

treatment. These individuals are the ones with the least influence in society. Njuguna and colleagues have provided these individuals with the opportunity of stating why they have not been able to continue treatment for their children. This is important, and highlights the contribution that health professionals can make to ensure that all children have the right to receive treatment. Health professionals and their organisations have a unique responsibility in trying to ensure that children receive treatment. Professional organisations, worldwide, must be unrelenting in their pressure on governments to provide:

- ▶ universal healthcare
- ▶ universal education
- ▶ essential medicines that are available and affordable.

These actions would have a major impact on reducing child mortality and morbidity throughout the world.

Competing interests None.

Provenance and peer review Commissioned; externally peer reviewed.



OPEN ACCESS

Open Access This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 3.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/3.0/>

To cite Choonara I. *Arch Dis Child* Published Online First: [please include Day Month Year] doi:10.1136/archdischild-2013-305257

Received 24 October 2013

Revised 18 November 2013

Accepted 20 November 2013



- ▶ <http://dx.doi.org/10.1136/archdischild-2013-305052>

Arch Dis Child 2014;0:1–2.
doi:10.1136/archdischild-2013-305257

REFERENCES

- 1 UNICEF. *The state of the world's children. Children with Disabilities*. New York, 2013.
- 2 Njuguna F, Mostert S, Slot A, *et al*. Abandonment of childhood cancer treatment in Western Kenya. *Arch Dis Child* Published Online First: 28 Mar 2014 doi:10.1136/archdischild-2013-305052
- 3 Robertson J, Forte G, Trapisida J, *et al*. What essential medicines for children are on the shelf? *Bull World Health Organ* 2009;87:231–7.
- 4 Arencibia ZB, Leyva AL, Peña YM, *et al*. Access to antiepileptic drug therapy in children in Camaguey Province, Cuba. *Int J Pharm Pract* 2012;20:390–4.
- 5 Barennes H, Sengkhayong K, Sambany EM, *et al*. Children's access to treatment for epilepsy: experience from the Lao People's Democratic Republic. *Arch Dis Child* 2011;96:309–13.



Why children do not receive treatment

Imti Choonara

Arch Dis Child published online April 19, 2014
doi: 10.1136/archdischild-2013-305257

Updated information and services can be found at:
<http://adc.bmj.com/content/early/2014/04/19/archdischild-2013-305257.full.html>

These include:

- | | |
|-------------------------------|--|
| References | This article cites 3 articles, 1 of which can be accessed free at:
http://adc.bmj.com/content/early/2014/04/19/archdischild-2013-305257.full.html#ref-list-1 |
| Open Access | This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 3.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/3.0/ |
| P<P | Published online April 19, 2014 in advance of the print journal. |
| Email alerting service | Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article. |
-

- | | |
|--------------------------|---|
| Topic Collections | Articles on similar topics can be found in the following collections
Open access (71 articles) |
|--------------------------|---|
-

Advance online articles have been peer reviewed, accepted for publication, edited and typeset, but have not yet appeared in the paper journal. Advance online articles are citable and establish publication priority; they are indexed by PubMed from initial publication. Citations to Advance online articles must include the digital object identifier (DOIs) and date of initial publication.

To request permissions go to:
<http://group.bmj.com/group/rights-licensing/permissions>

To order reprints go to:
<http://journals.bmj.com/cgi/reprintform>

To subscribe to BMJ go to:
<http://group.bmj.com/subscribe/>

Notes

Advance online articles have been peer reviewed, accepted for publication, edited and typeset, but have not yet appeared in the paper journal. Advance online articles are citable and establish publication priority; they are indexed by PubMed from initial publication. Citations to Advance online articles must include the digital object identifier (DOIs) and date of initial publication.

To request permissions go to:

<http://group.bmj.com/group/rights-licensing/permissions>

To order reprints go to:

<http://journals.bmj.com/cgi/reprintform>

To subscribe to BMJ go to:

<http://group.bmj.com/subscribe/>